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ABSTRACT

Although therapy (generically) is robust in its efficacy, different types of therapy do not appear to produce different types or degrees of benefit for clients. From this fact has emerged the perspective that it is factors that are common across therapies and nonspecific to any particular approach that hold the key to efficacy. This view, first logically reasoned and later supported by empirical research, has been reflected within the profession for 65 years. This paper reviews the history of the "common/nonspecific factors" perspective on therapeutic efficacy and the nature of various proposed "common factors." (Contains 40 references.) (Author)

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Running Head: COMMON FACTORS IN HISTORICAL PERSPECTIVE

Common Factors in Historical Perspective

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Abstract

Although therapy (generically) is robust in its efficacy, different types of therapy do not appear to produce different types or degrees of benefit for clients. From this fact has emerged the perspective that it is factors that are common across therapies and nonspecific to any particular approach that hold the key to efficacy. This view, first logically reasoned and later supported by empirical research, has been reflected within the profession for 65 years (Rosenzweig, 1936 through Wampold, 2001). This paper reviews the history of the "common/nonspecific factors" perspective on therapeutic efficacy and the nature of the various proposed "common factors."

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Common Factors in Historical Perspective

One of the interesting, and also perplexing, aspects of counseling and psychotherapy is the great diversity of different schools and orientations that exist in the field. In the mid-1960's, Garfield collected a list of over 60 different approaches to therapy and thought this to be an amazing phenomenon. A few years later, a report of the Research Task Force of NIMH (1975) noted over 130 different types of psychotherapy. Five years after that, Herink (1980) published an account of over 200 different forms of therapy, and within six years of Herink's publication, Kazdin (1986) referred to over 400 different therapeutic techniques. Whether the list of therapeutic approaches has grown or gotten smaller probably depends on the person doing the counting. But Garfield (1989), seeing a trend toward the proliferation of different forms of therapy, commented the if the then current rate of increase in therapies were to continue, at some point there would be a different form of psychotherapy for every person in the United States. Although it is highly doubtful that the extant approaches to counseling and psychotherapy is anywhere near this number, it seems probable that the number of approaches has continued to increase.[1]

For those subscribing to the mantra that counselors should attend to "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem and under *which* set of circumstances" (Paul, 1967, p. 111, italics in original), such a proliferation of interventions would seem desirable—allowing for a treatment selection paradigm according to which an intervention could be selected for a particular client from a cell or set of cells within a multidimensional (e.g., treatment x therapist x client x problems x setting) matrix (Stiles, Shapiro & Elliott, 1986).

But despite practitioners' often reported claim that they select or tailor their methods to the individual client, and in spite of how vigorously scholars urge attention to the question of which form of counseling/therapy has which effects with which types of clients, anecdotal and empirical evidence fails to support the former actions and gives every indication that the latter question has no answers today and may not find answers in the reasonable future.

In this regard, although there is considerable evidence that counselors representing different schools or orientations to therapy function in different ways that can be identified as representative of those specific schools (especially when the counseling approaches have been manualized), it is a frequently offered casual observation, based on the testimonies of both clients and counselors, that each of the various schools or approaches to counseling claims a fair number of successes.

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[1] Indeed, as Mahrer (1988) commented, "I know of no established theory of psychotherapy that declared bankruptcy because of research that failed to confirm, disconfirmed, or falsified its theoretical propositions and network of theoretical assumptions; nor is there a logical necessity for that to occur."

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The statistical data are consonant with these observations. In particular, meta-analytic research is compelling in its conclusion that despite differences in counselor behaviors and therapeutic procedures (and the theoretical modes that presumably guide them), roughly comparable and genuinely positive[2] therapeutic results/outcomes are obtained by the diverse approaches that counselors employ (see Wampold, 2001 for a current summary).

If the various forms of counseling and psychotherapy differ in their theory and procedures as much as they purport and appear to, question emerges as how one can explain that the differences in outcome are so small. Together the statistical interpretation and clinical perspectives are consistent with the thesis of "common factors." This thesis, initially based upon an arm-chair analysis of the irreducible minimum variables in any counseling or psychotherapy interaction between two persons, was first proposed by Rosenzweig in 1936. Understandably, the notion that there were common therapeutic features across different approaches to therapy could not have been proffered much earlier than this. But as noted by Wampold (2001), by the 1930's, the variety of psychoanalytic therapies—each claiming therapeutic success and interpreting this success as evidence supporting their respective theory and interventions—had proliferated to the point that process and outcome comparisons across therapies was possible (and inevitable).

Upon considering the testimonial claims of success (and eventually of superiority) of the proponents of the various approaches to therapy, it was Rosenzweig's (1936) contention that "Everybody has won and all must have prizes"—a phrase drawn from Lewis Carroll's 1865 book, Alice in Wonderland.[3] Rosenzweig went on to suggest (or at least strongly imply) that although there may be factors specific to particular therapeutic approaches that contribute to their efficacy, a reasonable explanation for the apparent equivalence of the sometimes vastly different orientations and interventions was the presence of "certain unrecognized factors...that may be even more important than those being purposely employed" (p. 412) and claimed as the specific therapeutic elements of particular approaches. His position, one that has been reflected by others over the past 65 years, was that it is basic factors, common to every form of therapy and that play essentially the same role in every therapy model, that account for whatever positive results are obtained by any of them.

To be sure, the proponents of each of the various individual theories and approaches to counseling and psychotherapy, believed that their theories and interventions captured the essence (and commonalities) of therapeutic change. Indeed, it was not uncommon for the proponents of

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[2] However see Epstein (1999) for an alternative perspective on the evidence supporting the beneficial effects of psychotherapy.

[3] In the relevant section of this book (Chapter 3), Alice finds herself swimming in a pool of tears at the head of a curious party of animals who have fallen in the water: a Duck, a Dodo, a Lory, an Eaglet, a mouse, and a few other animals. The animals and Alice make it to the shore, wet and grouchy. The mouse tries to dry them off by telling a dry story: he recites English history in flat, uninspired prose. The Dodo suggests another method of getting dry, as everyone seems to be as wet as ever. The Dodo suggests a Caucus Race. Alice and the animals line up and race around in circles, starting and stopping whenever they please. After a half-hour or so, they are all quite dry. The Dodo declares that they are all winners; "Everybody has won and all must have prizes." Alice is charged with the responsibility of giving prizes to all of them. All she has is a container of little candies, and so she gives them one candy each.

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particular theories and approaches to cast other theories and approaches within their own framework and to claim (implicitly) that the specific therapeutic factors of other therapeutic approaches were not only common to, but also explained by, their own framework. Shoben (1949), for example, argued that psychotherapy was fundamentally a problem in learning theory, and he proposed a conceptualization of therapy in terms of then current behavior theory. Dollard and Miller (1950) and Alexander (1963) did essentially the same, recasting psychoanalytic psychotherapy in terms of a common set of learning theory principles. And Krasner (1962) offered the notion that across diverse approaches to therapy, the therapist functioned as a "social reinforcement machine" (p. 61).

But these theory-specific "common factors" were not exclusively learning or behavioral factors. Fromm-Reichmann (1950) propose a set of general (analytic) principles of intensive psychotherapy that were presumed to apply across successful approaches to therapy. Rogers (1957) proposed that a general set of relationship principles that he believed to be common across effective counseling and psychotherapy (also see Truax & Carkhuff, 1967). Others (e.g., Cashdan, 1973; Haley, 1963; Strong & Claiborn, 1982; Claiborn & Lichtenberg, 1989) have proposed that it is through the resolution of interpersonal control conflicts that therapeutic change takes place.

Defining "commonalities" among diverse approaches to therapy by reframing them into the language of a specific therapy is one way to explain the finding of different approaches yield similar (positive) outcomes. But recasting the specific ingredients of one approach into the language of another is not what Rosenzweig (1936) was proposing, and it is not what we generally mean when discussing "common factors." Common factors are not theory- or approach-specific, and to suggest that psychoanalysis is really nothing but behavior therapy misses the point. The various approaches to counseling and psychotherapy <u>are</u> different—in theory and in their implementation. So how is it that they seem to yield similar outcomes? What do they have in common?

Schofield (1964; 1986) has suggested that to identify common factors across various forms of therapy, it may be most reasonable to start with a clear idea of their explicit differences. To the extent that individual systems of therapy have an articulated theory, it is easy point out differences among them at the level of theory. But as Schofield has noted,

> [T]heories do not have direct impact on the patient; patients do not "experience" the theories. Therapists of different theoretical persuasion may be of differing effectiveness because of differences in their respective theories only in measure as those theoretical differences lead to difference in the way in which the conduct therapy.

Although differences between theories need not be paralleled by notable differences in therapeutic techniques, there is evidence to suggest that theory-based treatments can be distinguished by the processes used and that these differences are quite consistent with the various theories underlying these approaches (e.g., DeRubeis, Hollon, Evans, & Bermis, 1982; Luborsky, Woody, McLellan, Brien, & Rosenzweig, 1982; also see Wampold, 2001). There is also evidence, however, of considerable variability in the implementation of specific types of therapy, even when that therapy has been manualized (Malik, et al., 2001).

Granting the theoretical and procedural the distinctiveness of different approaches to counseling, one factor common to all formal systems of therapy is that there is some theory—some more or less highly explicated theoretical formulation of client troubles (psychopathology) and the therapeutic process—and it has been suggested by Frank (1961), Hobbs (1962), Rosenzweig (1936), Schofield (1964) and others that some sort of "systematic ideology" may be an essential element in successful therapy.

> Whether the therapist talks in terms of psychoanalysis or Christian Science is from this point of view relatively unimportant as compared with the formal consistency with which the doctrine employed is adhered to, for by virtue of this consistency the patient receives a schema for achieving some sort and degree of personality organization. (Rosenzweig, 1938)

Examining the broad outlines of therapy, other structural properties emerge which are unavoidably common to all form of counseling. These common factors do not contribute to differences in the conduct of the therapy and they cannot explain any difference in results that might be demonstrated by different approaches. But it is the contention of those voicing a "common factors perspective" that these common factors may well account for most of the positive results which each of the various schools of therapy claim.

The specific common factors proffered as accounting for therapeutic results have been "numerous and varied" (Patterson, 1989). And as a result of different authors focusing on different levels and aspects of the counseling enterprise, diverse conceptualizations of the commonalities across different therapies have emerged. Historically, these conceptualizations seem are of several types: (a) therapist factors, (b) client factors, (c) relationship factors, and (d) contextual factors—this latter conceptualization being a sort of meta-conceptualization subsuming and integrating the other three.

Therapist Factors

Therapist factors—broadly defined as attitudes, qualities and conditions provided by therapists in their relationships with clients—are therapist qualities that cut across different schools despite their differences in response modes, techniques and verbal content. Stiles, Shapiro and Elliott (1986) propose two broad categories of these factors: (a) warm involvement with the client and (b) the communication of a new perspective on the client's person and situation (p. 172). Perhaps the best known example of warm involvement factor is the triad of necessary and sufficient conditions proposed by Rogers (1957). The new perspective factor was described by Frank (1973) as the process by which the therapist provides the client with a new "assumptive word."

Client Factors

Within this group of common factors are the notions (a) that clients enter therapy sharing a common "ailment" and motivation (Frank [1973] describes this as a sense of demoralization) and (b) that the client involvement (focusing and experiencing [Gendlin, 1970, 1978]) and self-disclosure (Jourard, 1971), and expectancies (e.g., Frank, 1983; Goldstein, 1962; Schofield, 1964) are critical to successful therapy.

Relationship Factors

This group of common factors includes the elements defining the therapeutic alliance (also called "the working alliance" or "helping alliance"). In general such an alliance is distinguished by three aspects: (a) an emotional bond between the client and therapist, (b) the quality of the client and counselor involvement in the tasks of therapy, and (c) the concordance between the client and the therapist on the goals of counseling (Bordin, 1979). Also included in this group of factors would be the status differential of the counselor and client (Schofield, 1964; Haley,1963; Frank, 1973).

Contextual Factors

Historically, Rosenzweig's contextual perspective on counseling and psychotherapy was the first "common factors" model proposed. Others articulating this perspective have been Frank (1961, 1973, 1982, 1991), Hobbs (1962) and , Schofield (1964, 1986)—and most recently and empirically, Wampold (2001). As noted above, the contextual model of therapy subsumes and integrates many of the features or components presented as therapist, client and relationship "common factors. Although presented somewhat uniquely by each of its various proponents, four features have been proposed as common to or shared by all forms of counseling and psychotherapy and which create the context for therapeutic change include the following.

1. A special relationship between the client and the therapist. This has been described as "an emotionally charged, confiding relationship with a helping person" (Frank, 1982), but has been considered to include as well features such as (a) a status differential between the therapist and client in which the therapist is in an ascendant (and socially sanctioned) helping position relative to the client, (b) he client's confidence in the therapist's competence and desire to be of help, (c) the client's expectation of help, and (d) the controlled, circumscribed, and limited nature of the relationship (see Hobbs, 1962; Schofield, 1964, 1986).

2. A healing setting. Such a setting is sets counseling and therapy apart from the client's other environments, sanctioning the locale as "place of healing" (Frank, 1973, p. 326) heightening the therapist's prestige and status differential, and providing a safe and protected place so self-examination, emotional expression, and other tasks of therapy.

3. A rationale or "myth" that provides a plausible explanation the client's symptoms and distress. This rationale (also described as a "systematic ideology" [Schofield, 1964, 1986] or more routinely as a "theory of psychotherapy") additionally prescribes a therapeutic "ritual" or the series of tasks and procedures to be implemented by the client and therapist

4. A therapeutic ritual or set of procedures or tasks prescribed (or informed) by the theory. It is this ritual, these procedures, that characterize the therapy process. It may include such diversity activities as graduate exposure/extinction procedures, catharsis, disputing irrational beliefs, primal screaming, dream interpretation, free association, selective reinforcement, role playing, etc.

It is with particular regard to features 3 and 4 that the various approaches to therapy are distinguished, and it is at this level of analysis that each of the several hundred approaches to therapy are most clearly different. Nevertheless, it is the contention of subscribers to a common

factors perspective that it is not the specific theory, rationale or myth or the specific therapeutic procedures or ritual that are important. Rather it is held that a client's symptomatic and emotional relief derives from the fact that an explanation for the client's symptoms and distress is provided to the client by a caring,. trustworthy, experienced "socially sanctioned healer" with a "designated healing setting" and folllowed by the implementation of a conceptually consistent set of procedures is applied "as therapy" to the client's problems.

Together, these factors—common across the various approaches to counseling and psychotherapy—are presumed to influence client attitudes and behavior in certain common and consistent ways, including (a) providing new opportunities for cognitive and behavioral learning, (b) enhancing the client's hope/expectancy of relief, (c) providing success experiences that enhance the client's sense of efficacy, mastery, and competence, (d) combat and help overcome the client's sense of demoralization and alienation, and (e) arouse the client emotionally.

Conclusion

Now considered one of three central thrusts of the "psychotherapy integration movement (Grencavage & Norcross, 1990), the common factors perspective on therapy is considered by some to be one of most significant and potentially important trends in psychotherapy research (Bergin, 1982), and it is addressed routinely in contemporary reviews of psychotherapy (e.g., Lambert & Bergin, 1994). Most recently, the common factors perspective (reflected as a contextual model of therapy) has achieved considerable empirical prominence as a result of Wampold's carefully documented deconstruction of the "specific factors" view of therapy which is driving the EVT (empirically validated treatment) movement.

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